MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING

INITIAL ASSESSMENT - SOCIAL AND MEDICAL

DFS CO. NO.	☐ CASH
LOAD NO.	☐ XIX

All questions on this form must be answered – write N/A if not applicable. Blank areas will result in return of document and delay in payment.

A. SOCIAL ASSESSMENT

1. PERSON'S NAME (LAST, FIRST, MI)	2. DCN	3. DOB	4. SOCIAL SECURITY NUMBER

5. SEX

6. RACE

7. EDUCATION LEVEL
- ☐ GRADE SCHOOL
- ☐ HIGH SCHOOL
- ☐ COLLEGE
- ☐ OTHER

8. OCCUPATION

9. CURRENT LOCATION (ADDRESS)

10. WAS PERSON RECEIVING PERSONAL CARE PRIOR TO NF PLACEMENT? ☐ YES ☐ NO

11. NAME OF PROPOSED NURSING FACILITY PLACEMENT, PHONE #

12. DATE ADMITTED TO NF

13. PLTC # (R#)

14. PERSON'S LEGAL GUARDIAN ☐ OR DESIGNATED CONTACT PERSON ☐
NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____

B. MEDICAL ASSESSMENT

Attach additional sheets of information if necessary.

1. HEIGHT
2. WEIGHT
3. B/P
4. PULSE
5. DATE OF LAST MEDICAL EXAM

6. RECENT MEDICAL INCIDENTS (i.e., CVA, SURGERY, FRACTURE, HEAD INJURY, ETC., AND GIVE DATE)
RESIDUAL EFFECTS: _____

7. SPECIAL LAB TESTS AND FREQUENCY

8. PRESCRIPTION DRUGS (DOSAGE AND FREQUENCY, INCLUDING PRNS; SHOULD CORRELATE WITH DIAGNOSES)

1.	4.	7.
2.	5.	8.
3.	6.	9.

9. LIST ALL DIAGNOSES (SHOULD CORRELATE WITH MEDICATIONS) (INCLUDE PSYCH DX)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

10. POTENTIAL PROBLEM AREAS AND/OR ADDITIONAL COMMENTS

11. STABILITY
- ☐ 1. IMPROVING
- ☐ 2. STABLE
- ☐ 3. DETERIORATING
- ☐ 4. UNSTABLE

12. LEVEL OF CARE REQUESTED BY PERSON'S PHYSICIAN (CHECK ONE) ☐ NF ☐ RCF ☐ ICFMR ☐ MH ☐ SUPPLEMENTAL NC ☐ HOME CARE

13. MENTAL STATUS (CHECK ALL THAT APPLY)
- ☐ ORIENTED TO: ☐ person, ☐ place, ☐ time
- ☐ THINKS CLEARLY
- ☐ LETHARGIC
- ☐ ALERT
- ☐ MEMORY: ☐ good, ☐ fair, ☐ poor

14. BEHAVIORAL INFORMATION (CHECK ONE BOX FOR EACH)

NONE	MIN	MOD	MAX	
☐	☐	☐	☐	CONFUSED
☐	☐	☐	☐	WITHDRAWN
☐	☐	☐	☐	HYPERACTIVE
☐	☐	☐	☐	WANDERS
☐	☐	☐	☐	SUSPICIOUS
☐	☐	☐	☐	COMBATIVE
☐	☐	☐	☐	SUPERVISED FOR SAFETY
☐	☐	☐	☐	CAUSES MGT. PROBLEMS
☐	☐	☐	☐	CONTROLLED WITH MEDICATION(S)

15. FUNCTIONAL IMPAIRMENT (CHECK ALL THAT APPLY AND GIVE RATIONALE)
- ☐ VISION _____
- ☐ HEARING _____
- ☐ SPEECH _____
- ☐ AMBULATION _____
- ☐ MANUAL DEXTERITY _____
- ☐ TOILETING _____
- ☐ PATH TO SAFETY _____

16. ASSESSED NEEDS (CHECK APPROPRIATE BOX FOR EACH; GIVE RATIONALE PLUS AMOUNT OF STAFF ASSISTANCE NEEDED. (YOU MUST USE GUIDE #1 ON BACK.)

NONE	MIN	MOD	MAX	
☐	☐	☐	☐	1. MOBILITY
☐	☐	☐	☐	2. DIETARY
☐	☐	☐	☐	3. RESTORATIVE SERVICES
☐	☐	☐	☐	4. MONITORING
☐	☐	☐	☐	5. MEDICATION
☐	☐	☐	☐	6. BEHAVIOR/MENTAL COND.
☐	☐	☐	☐	7. TREATMENTS
☐	☐	☐	☐	8. PERSONAL CARE
☐	☐	☐	☐	9. REHAB. SERVICES

17. POTENTIAL FOR REHAB ☐ GOOD ☐ FAIR ☐ POOR

18. PATIENT REFERRED BY	19. FORM COMPLETED BY	
NAME OF INDIVIDUAL OR AGENCY	SIGNATURE OF INDIVIDUAL ▶	
ADDRESS	RELATIONSHIP TO PATIENT	
TELEPHONE	TELEPHONE	DATE

DA CENTRAL OFFICE USE ONLY

LEVEL OF CARE DETERMINATION BY DIVISION OF AGING CENTRAL OFFICE

☐ 1 NF ☐ 2 IMR ☐ 3 MH ☐ 4 SNC ☐ 5 NONE

NEXT EVALUATION DATE	SIGNATURE DATE
STATE PHYSICIAN'S SIGNATURE ▶	

XX INSTRUCTIONS FOR COMPLETING THE DA-124A/B FORM
INITIAL ASSESSMENT - SOCIAL AND MEDICAL

A. SOCIAL ASSESSMENT-

1. Patient's name (LAST, First, Middle)
2. Medicaid# - if unknown **LEAVE BLANK**
3. Date of birth
4. Social Security Number
5. Male or female
6. White, Black, Native American, Chinese, Japanese, etc.
7. Highest grade level completed by the person - if you check OTHER give brief description, e.g., Special Education
8. If never worked, retired, etc., so state. Also, if he/she worked in a Sheltered Workshop, so state.
9. Give street address, city, state, zip. This is not the place for the name of the proposed facility.
10. Refers to home-based services provided by the Division of Aging.
11. Use FULL name of facility (not initials) and give phone number, not address.
12. If not yet admitted, leave blank.
13. Give R# you obtained from the Hotline (1-800-392-0210). If one was not assigned, leave blank.
14. Check box for guardian or contact person and give full name, street address, city, state, zip and phone number.

B. MEDICAL ASSESSMENT - NOTE: ALL SECTIONS MUST BE ANSWERED. BLANK AREAS WILL RESULT IN RETURN OF DOCUMENT AND DELAY IN PAYMENT.

1. Height
2. Weight
3. Blood pressure
4. Pulse
5. Date of last medical examination.
6. CVA, MI, Surgery, Fracture, Head Injury, Fall, Motor vehicle accident, etc., AND give date it occurred.
   Residual effects - left sided weakness, comatose, developmental disability, dizziness, etc.
7. UA, CBS, etc., & frequency. If none, so state.
8. List ALL drugs, including PRNs, and give dosage and frequency, MUST correlate with diagnoses.
9. Include ALL diagnoses, including "history of". Must correlate with prescription drugs and information on the DA124C form.
   NOTE: If patient has ever been diagnosed with cerebral palsy, epilepsy, autism, MS, MD, etc., list here AND give patient's age at time of onset.
10. Use this area to give pertinent information not mentioned elsewhere.
11. Person's condition at this time.
12. NF=skilled or intermediate nursing facility; RCF=residential care facility
    ICF/MR=intermediate care facility for the mentally retarded; MH=mental hospital;
    SUPPLEMENTAL NC=cash grant bed; HOME CARE=in-home services.
13. Check **all** that apply. If comatose or semicomatose, list on #16.
14. Check one box for each.
15. VISION - does person wear glasses? Blind from birth? Blind from glaucoma?
    HEARING - hard of hearing? Hearing aide? Deaf? Deaf since birth?
    SPEECH - impaired since stroke? Impediment?
    AMBULATION - short distance only? Non-weight bearing? Bedfast?
    MANUAL DEXTERITY - fair? Needs ROM?
    TOILETING - occasionally incontinent? Frequently? Catherization?
    PATH TO SAFETY - could negotiate alone? Mentally able but not physically? VERY IMPORTANT FOR NF PLACEMENT.
16. Follow directions on the form. The most common reason for returns is negligence in this area of the form. It is most important that the State Physician has enough information to certify that the person is medically eligible for nursing facility placement. Please give a good description (in each category) of the patient's care needs, how many staff it takes to assisting (or supply) that care, and how often the care is given. (Use short statements, e.g., PT 5X weekly per 1 therapist.) USE GUIDE #1 ON THE BACK OF THE FORM. Also see: 2000 State Regulation book, 13 CSR 15-9.030 (K), Chapter 9 Certification.
17. Check one.
18. Name, address and phone number of hospital, out-of-state facility, home health agency, etc. Referring person to nursing facility. If no facility, give name, address and phone number of person making referral.
19. Person who completes the form must sign *and* date; give relationship to patient (or job title) and phone # where you may be reached. **NOTE**: THE PERSON'S PHYSICIAN IS NOT REQUIRED TO SIGN THE DA124A/B FORM.

DO NOT WRITE IN THE BOX MARKED 'DA CENTRAL OFFICE USE ONLY'.
QUESTIONS? Call COMRU @ 573-526-8609.